COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

NOTIFICATION TO POLICE
REGARDING
ABSENCE WITHOUT AUTHORIZATION

Notification to: ☐ Local Town/City: _____
Contact Person

Town/City: _____
Contact Person

Town/City: _____
Contact Person

☐ State _____
Contact Person

☐ Campus _____
Contact Person

DMH Area _____ Date _____ Time of Notice _____

Facility _____ Address _____

Facility Contact Person _____ Telephone _____

Patient's Name _____ DOB _____ Legal Status _____

Sex: ☐ M ☐ F Home Address: _____

Pursuant to 104 CMR 27.16 (2)(d), you are hereby notified that the just named patient was absent without authorization from this facility as of _____ at _____ . Steps
date time

are being taken to safely return this patient to the facility. If you have any information that would assist us in securing the patient's safe return, please contact the facility contact person listed above. You will be notified when the patient is returned or discharged from the facility.

Description of Incident _____

_____

Last seen _____

Physical Description: Photo attached ☐ Yes ☐ No

Height _____ Weight _____
Hair Color _____ Skin Color _____
Eye Color _____
Clothing _____
Other Significant Identifying Characteristics (e.g., tattoo, birthmark) _____

_____

Risk Factors:

Risk of Harm to Self? ☐ Yes ☐ No Describe: _____

Risk of Harm to Others? ☐ Yes ☐ No Describe: _____

Tendency to use Weapon? ☐ Yes ☐ No Describe: _____

Instructions: Individual copies of this form shall be sent to any or all of the above, as appropriate, and filed in the patient's medical record.
Form AWA-2